APPLICATION FOR CERTIFICATION AS AN OCCUPATIONAL THERAPIST OR OCCUPATIONAL THERAPY ASSISTANT

To Practice in the State of Indiana

State Form 43826 (R5 / 12-02)

Approved by the State Board of Accounts, 2002

*Social Security number is required pursuant to I.C. 4-1-8-1.

Health Professions Bureau
402 W. Washington St. Room 041
Indianapolis, IN 46204
Telephone number: (317) 234-2051
Email address: hpb6@hpb.state.in.us

Application fee	Temporary permit fee
Date fee paid *(month, day, year)*	Date fee paid (*month, day, year*)
Receipt number	Receipt number
Certification number	Temporary permit number
Certification issuance date *(month, day, year)*	Temporary permit issuance date *(month, day, year)*

APPLICANT

Attach two (2) passport type quality photographs of yourself taken within the last eight weeks. Please sign each photo at the bottom. Negatives and Polaroids are not acceptable.

DO NOT WRITE ABOVE THIS LINE

APPLICANT INFORMATION

Name *(last, first, middle, maiden)*		Social Security number *
Address *(street and number or Rural Route)*		
City, state, ZIP code		E-mail address
Telephone number *(daytime)* ( )	Date of birth	Birth place

BASIS FOR CERTIFICATION

Do you desire a temporary permit? ☐ Yes ☐ No

☐ Examination ☐ Endorsement

Please check one: ☐ Occupational Therapist ☐ Occupational Therapy Assistant

If you are applying by examination, what date will you be taking the examination?
(Please list date of examination.)

Have you previously filed an application for certification as an Occupational Therapist or Occupational Therapy Assistant in the state of Indiana or any other state?
(If yes, please give details as to where and when)
☐ Yes ☐ No

Have you previously taken the certifying examination for an Occupational Therapist or Occupational Therapy Assistant?
(If yes, please list date and place)
☐ Yes ☐ No

Have you ever failed the certifying examination for an Occupational Therapist or Occupational Therapy Assistant?
(If yes, please list date and place.)
☐ Yes ☐ No

Occupational Therapist / Occupational Therapy Assistant Degree Granted by:

Name of school	Location	Date of graduation *(month, day, year)*

UNDERGRADUATE AND GRADUATE TRAINING

NAME OF SCHOOL	LOCATION	FROM MO. / YR.	TO MO. / YR.	DEGREE

List all states, including Indiana, in which you have been licensed to practice any regulated health occupation.				
STATE	**TYPE OF LICENSE/CERTIFICATE**	**NUMBER**	**DATE ISSUED**	**CURRENT STATUS**

PLACES OF EMPLOYMENT SINCE GRADUATION			
NAME AND ADDRESS OF EMPLOYER	**RESPONSIBILITIES**	(Begin) **DATE**	(End)

PLACES YOU HAVE LIVED SINCE GRADUATION	
GENERAL LOCATION	**DATE**

* If your answer is "yes" to any of the following, explain fully in a sworn affidavit, including all related details. Include the violation, location and date. Falsification of any of the following is grounds for permanent revocation of a certification or permit issued pursuant to this application.

1. Has disciplinary action ever been taken regarding any health license, certificate, registration or permit that you hold or have held? ☐ Yes ☐ No
2. Have you ever been denied licensure registration or certification in any state *(including Indiana)* or country? ☐ Yes ☐ No
3. Are you now, or have you ever been treated for a drug abuse or an alcohol problem? ☐ Yes ☐ No
4. Have you ever been charged with drug addiction? ☐ Yes ☐ No
5. Have you ever been convicted of, pleaded guilty to or *nolo contendere* to any offense, misdemeanor or felony in any state? *(Except for minor violations of traffic laws resulting in fines)* ☐ Yes ☐ No
6. Have you ever been denied staff membership or privileges in any hospital or health care facility or had such membership or privileges revoked, suspended or subjected to any restrictions, probation or other type of discipline or limitations? ☐ Yes ☐ No
7. Have you ever been censured, reprimanded or requested to withdraw, resign or retire from any hospital or health care facility in which you have trained, held staff membership or privileges or acted as a consultant? ☐ Yes ☐ No
8. Have you ever had a malpractice judgement against you or settled any malpractice action? ☐ Yes ☐ No

APPLICATION AFFIRMATION

I hereby swear or affirm, under the penalties of perjury, that the statements made in this application are true, complete and correct.

Signature of applicant	Date *(month, day, year)*

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize, request and direct any person, firm, officer, corporation, association, organization or institution to release to the Health Professions Bureau of Indiana, any files, documents, records or other information pertaining to the undersigned, requested by the Bureau or any of its authorized representatives in connection with processing my application for certification as an occupational therapist or occupational therapy assistant.

I hereby release the aforementioned persons, firms, officers, corporations, associations, organizations and institutions from any liability with regard to such inspection or furnishing of any such information.

I further authorize the Health Professions Bureau of Indiana to disclose to the aforementioned organizations, persons, and institutions any information which is material to my application and I hereby specifically release the Bureau and the Committee from any and all liability in connection with such disclosures.

A photostatic copy of this authorization has the same force and effect as the original.

AFFIRMATION

I hereby swear or affirm that I have read the above statements and agree to same.

Date *(month, day, year)*	Signature of applicant